

Open Door Forum Newsletter

June 2003

Volume 2, Issue 6

Hot Announcements!

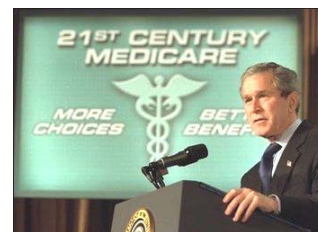
Stats of the Month!

2,087 teleconference lines were open to individual and group participants and more than **196** guests visited with the CMS Administrator and policy leaders during the Open Door Forums held in May.

Through May 2003, more than **26,891** guests have participated in the forums since October 2001!

Medicare Modernization Legislation

CMS is working closely with Congress to build upon President George W. Bush's Framework to Modernize Medicare by offering seniors more choices and better benefits.



Through the efforts of everyone at CMS -from the Administrator to the Policy Analysts to our Office of Legislation- Congress was well-prepared as Medicare legislation passed the Senate and the House June 26. CMS, Congress, and the President are all working hard to ensure that final legislation will meet the needs of our seniors and to ensure that Medicare is modern, compassionate, and works better for the consumers who deserve affordable and quality healthcare as well as for the providers who deliver it.

For more information on the legislation, please click the following links:

[Senate Finance Committee](#), [House Ways & Means Committee](#), [House Energy & Commerce Committee](#)

ESRD Report, Demo, & Informational Meeting

End Stage Renal Disease Report to Congress

As required by the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement Act of 2000 (BIPA), CMS was requested to submit to Congress a report on the bundled outpatient Medicare End Stage Renal Disease (ESRD) prospective payment system (PPS). That report, submitted in early May, examined the feasibility of replacing cost based methods of reimbursement with PPS methods for outpatient ESRD services by increasing the services subject to the dialysis bundled rate.

The report presents an overview of the ESRD composite rate and its limitations, explains the issues that must be addressed before an expanded or bundled PPS can be implemented, and includes the most important findings from the feasibility phase of CMS' sponsored research conducted by the Kidney Epidemiology and Cost Center of the University of Michigan.

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Information Disclaimer: The information provided in this newsletter is only intended to be general summary information to the public. It is not intended to take the place of either the written law or regulations.

Links to Other Resources: Our newsletter may link to other federal agencies and private organizations. You are subject to those sites' privacy policies. Reference in this newsletter to any specific commercial products, process, service, manufacturer, or company does not constitute its endorsement or recommendation by the U.S. Government, HHS or CMS. HHS or CMS is not responsible for the contents of any "off-site" resource referenced.



The report concludes that current data sources are adequate for proceeding with the development of a bundled ESRD PPS, that case mix is an important variable for risk adjusting payments in order to target appropriately greater payments to facilities treating more costly resource intensive cases, and that current data provides a foundation for monitoring quality of care and patient outcomes in a revised payment system. For more information on the report, please find time to participate in our ESRD and Clinical Labs Open Door Forum (www.cms.hhs.gov/opendoor/listservs.asp).

End-Stage Renal Disease Management Demonstration & Informational Meeting

A notice informing interested parties of an opportunity to apply for a waiver allowing them to participate in the ESRD Disease Management Demonstration can be found in the *Federal Register* at: www.cms.gov/providerupdate/regs/cms5003n.pdf, which outlines CMS plans to increase the opportunity for Medicare beneficiaries with ESRD to receive integrated disease management services and to test the effectiveness of paying for services received by these beneficiaries in a new way.

The demonstration aims to test the effectiveness of disease management models to increase quality of care for ESRD patients while ensuring that this care is provided more effectively and efficiently. A competitive application process will be used to select organizations to participate in this demonstration. More information will be made available at a July 14 ESRD Informational Meeting. While details of this meeting will become available through the *Federal Register* after July 1, please feel free to e-mail questions to ESRDDemo@cms.hhs.gov for further details.

Determining Payment for Cost Outliers Under Certain Prospective Payment Systems (PPS)

CMS recently announced a final rule that revises the methodology for determining payments for extraordinarily high-cost cases (cost outliers) made to Medicare-participating hospitals under the acute care hospital inpatient prospective payment system (IPPS).

Because some hospitals' recent rate-of-charge increases greatly exceed rate-of-cost increases, other hospitals were inappropriately denied access to outlier payments. Our new regulation will ensure that outlier payments are made only for truly expensive cases. To review the final regulation in its entirety, please click here: www.cms.hhs.gov/providerupdate/regs/cms1243f.pdf

Long-Term Care Hospital PPS

On June 9, CMS published the final rule for the Long-Term Care Hospital (LTCH) Prospective Payment System (PPS) annual payment rate updates and policy changes in the *Federal Register*.

This final rule establishes the annual update of the payment rates for the Medicare PPS for inpatient hospital services provided by LTCHs. It also changes the annual period for which the rates are effective. The rates will be effective from July 1 to June 30, 2004 instead of from October 1 through September 30, 2004 establishing a "long-term care hospital rate year" (LTCH PPS rate year).

For more info, please click here: www.cms.gov/providerupdate/regs/cms1472f.pdf



Outpatient Therapy Service Limitations

On June 17, CMS hosted a Special Open Door Forum to discuss the implementation of outpatient therapy service limitation to present both basic information and detailed specifics of the limitations –also known as therapy caps. With more than 800 participants in person and via teleconference, CMS policy leaders explained the law that, beginning July 1, will limit most per-beneficiary outpatient rehabilitation services. The limit is \$1,590 for physical therapy services (including speech language pathology) and an additional \$1,590 for occupational therapy services.

The annual limits will not apply to services furnished directly or under arrangement by a hospital to an outpatient, or to hospital inpatients not in a covered Part A stay. The full annual limit will be applied for the six month (July 1 – December 31) period. Effective July 1 and for dates of service on or after July 1, the Common Working File (CWF) will track the financial limitation.

CMS has no choice but to implement these caps based on legislation that Congress enacted in 1997. For more details of the limits, please review CMS program memorandum AB-03-085 by clicking here: www.cms.hhs.gov/manuals/pm_trans/AB03085.pdf

Outcome and Assessment Information Set (OASIS)

The University of Colorado's OASIS Technical Expert Panel (TEP) met June 24 – 25 to continue to systematically work through comments submitted in regards to OASIS refinements. The July 2 Home Health, Hospice, and Durable Medical Equipment Open Door Forum will be extended by a half-hour to allow time for a thorough recap of the meeting facilitated by the University of Colorado.

For more information regarding policy and technical information related to OASIS for use in home health agencies (HHAs), please click here: www.cms.hhs.gov/oasis/default.asp Information found there is intended to assist HHAs, State agencies, software vendors, professional associations and other Federal agencies in implementing and maintaining OASIS.

Home Health Information Resource for Medicare

CMS is happy to announce our new "Home Health Information Resource for Medicare." There are many features on the page including an alphabetical listing of topics, an OASIS section, listserv access and a highlight section to emphasize current home health activities. For more info, click here: www.cms.gov/providers/hha

Hospital History & Physical Requirements

A topic of discussion of great interest during the most recent Nurses & Allied Health Open Door Forum regarded the Survey & Certification letter clarifying the history and physicals (H&P) requirements for hospital patients. The letter, S&C-02-15 and dated January 28, 2002, can found at: www.cms.hhs.gov/medicaid/lcsp/lcsmemos.asp. Below is a summary of the memo:

-An H&P must be performed by an MD/DO or oromaxillofacial surgeon, for patients receiving oromaxillofacial surgery, no more than 7 days prior to or 48 hours after hospital admission/outpatient surgery but prior to surgery.

-H&P completed more than 7 days prior to hospital admission/outpatient surgery are considered as meeting the currency requirement if a clinically appropriate patient assessment is performed within 30 days prior to hospital admission/outpatient surgery, an update note is written which addresses any changes in the patient's condition and describes the patient's current status, and the update note is recorded on or attached to the H&P and placed in the patient's medical record within 48 hours of hospital admission but prior to surgery.

-All or part of the H&P may be delegated to other practitioners in accordance with State law and hospital policy, but the MD/DO must sign the H&P and assume full responsibility for the H&P. This means that an Nurse Practitioner or a Physician Assistant meeting these criteria may perform the H&P.

-An H&P performed more than 30 days prior to hospital admission or outpatient surgery does not comply with the currency requirements and a new H&P must be performed.

A Few Words on Quality!

-Nursing Home Quality Initiative

The Nursing Home Quality Initiative (NHQI) efforts are well underway. The Nursing Home Compare website (www.medicare.gov/NHCompare/home.asp) is being updated quarterly with the national publicly reported nursing home quality measures. The most recent update occurred on May 15, posting quality measures for Quarter 4 2002. Feedback from users has been generally positive with the number of hits to the website averaging 31,000 per day. The **1-800-MEDICARE** phone line is an additional help to consumers with requests for nursing home quality information. Quality Improvement Organizations (QIOs) continue to be a support and resource to nursing homes, helping them to interpret and understand their quality measure information. QIOs have sustained their established partnerships and collaborations with stakeholders and nursing homes in their states, to improve quality of care as measured by the publicly reported quality measures. For statewide improvement, every QIO is focusing on pressure ulcers and at least one of the pain measures. Nationally, 14 percent (2,330 NHs) of nursing homes have volunteered for and are currently receiving valuable on-site technical assistance and individualized quality improvement support from QIOs. For more information or questions about the nursing home quality measure information and any statewide quality improvement activities, please contact the QIO in your state.

-Home Health Quality Initiative

On May 1, Secretary Tommy Thompson announced the new Home Health Compare website on www.medicare.gov. For the first time, home health quality measures are available to consumers to provide additional information to help them choose a home health agency. Home Health Quality Measures are available for home health agencies in the following Phase I States: Florida, Massachusetts, Missouri, New Mexico, Oregon, South Carolina, West Virginia and Wisconsin. Home health quality measures will be available nationwide in the Fall of 2003.

Although quality measurement data are currently not available on the home health agencies in the non-Phase I States, home health agencies in the non-Phase I States are encouraged to review their demographic information on Home Health Compare and begin to make revisions. For changes or corrections to the demographic information displayed on Home Health Compare, please contact the State Survey Agency OSCAR/ASPEN Coordinator in your state. Contact information for the State Survey Agency OSCAR/ASPEN Coordinator is available on the HHQI website found here: www.cms.hhs.gov/quality/hhqi. For the changes to be incorporated into the national release of Home Health Compare in the Fall, please make changes to the demographic information by July 8.

For more information about the Home Health Quality Initiative, please visit the HHQI website. For more information or for answers to questions about the quality measures, please contact the QIO in your State.

Quick Notes: Medicare Provider Analysis and Review & Hospice Volunteer Hours

MEDPAR –Starting Monday, June 16, CMS began shipping the 2002 MEDPAR encrypted file per requests received thus far. New procedures for requesting MEDPAR encrypted files, now classified as Limited Data Sets under the HIPAA Privacy Rule, can be found here: www.cms.hhs.gov/data/purchase.

Hospice –Clearing up any miscommunication during discussions during a May Home Health, Hospice, & DME forum, CMS has not modified policy on the counting of volunteer hours for hospice conditions of coverage.

There were, however, questions concerning documenting the cost savings achieved through the use of volunteers. Those questions were immediately answered through an explanation of our regulation at 42 CFR § 418.70 (d) -please click here to review this section of the regulation: [42 CFR § 418.70 \(d\)](http://www.federalregister.gov). The survey procedures and interpretive guidelines are found in Appendix M of the State Operations Manual found here: www.cms.hhs.gov/medicaid/hospice/som-ap-m.pdf

The hospice resource for survey and certification issues, which can be located at: www.cms.hhs.gov/medicaid/hospice/, also contains links to Appendix M, section 418.70. This site contains survey and certification policy memos related to hospice and links to the survey procedures and interpretive guidelines, which are used by the hospice surveyors.

Relief to Federally Qualified Health Centers

After several months of discussions during some of our most recent Open Door Forums and a great amount of effort on behalf of one of our contractors, UGS, and the Health Research Services Administration (HRSA), CMS is pleased to announce a new, expedited process for Federally Qualified Health Centers (FQHCs) to resolve issues associated with provider agreements that required existing FQHC to obtain a separate and distinct billing identification mechanism for each of their practice location or satellites.

Efforts have resulted in the following to reduce this quite burdensome requirement:

- Satellite locations will only have to complete a small fraction of our CMS-855A enrollment form.
- UGS will provide prompt initial distribution of forms, which were previously only obtainable later through the Regional Office.
- UGS has hired an ombudsman and additional personnel to handle just FQHCs.
- We are participating in an educational campaign, which includes contractor personnel attendance at provider forums.

For answers to questions and to obtain more information, please feel free to participate in our next rural health open door forum.

The subject of the latest CMS Market Update is the nursing home industry. The industry continues to struggle with rising liability costs, the October 2002 sunset of Medicare's add-on payment provisions, and risk to Medicaid payments as States balance tight budgets. For more information on this analysis, please click here: www.cms.gov/marketupdate/

CMS' Data Assessment & Verification Contract -MDS

On Friday, June 20 CMS sponsored a satellite broadcast to introduce the Minimum Data Set (MDS) Data Assessment and Verification (DAVE) project and process to the long term care community, the State agency staff and the Fiscal Intermediary staff. During the broadcast, the audience learned about the primary purpose of the DAVE contract – to assure the accuracy of MDS data – and the key components of the DAVE process – data analysis, offsite and onsite reviews and education to improve the accuracy of the data.

Following a review of the major DAVE activities, the DAVE team presented “helpful hints” on ways to improve selected MDS items. If you missed the broadcast or would like to review sections of the broadcast, please visit CMS' training website (<http://cms.internetstreaming.com>) to learn more about other broadcasts.

More information about the DAVE contract can be found on CMS' website at: www.cms.hhs.gov/providers/psc/dave

HIPAA News You Need to Use!

HIPAA Outreach has been busy this month expanding resources for providers. With the creation of free small provider workshops throughout June in Takoma, Las Vegas, Syracuse and Boise, CMS' Office of HIPAA Standards (OHS) has further assisted the goal of HIPAA compliance by October 16. These workshops focus on implementing critical electronic transactions and code set requirements.

The workshop provides aids such as checklists, to do's and a CD containing the power-point presentation given at the workshop (found here: www.cms.hhs.gov/hipaa/hipaa2/events/default.asp#vendorforu)

OHS is also working on the release of the "HIPAA Information Series" – ten papers devoted to electronic transactions and code sets that will be available in English and in Spanish.

To all health care providers, OHS would like to ask: are you testing? Less than four months remain until October 16! Will you be ready? CMS is here to help answer your questions. Check out our website for more information at: www.cms.hhs.gov/hipaa/hipaa2

Or, call us toll-free at (866) 282-0659 for non-privacy related issues.

Don't Forget!

A new feature of the CMS Open Door Forum Newsletter, this quick reminder is provided as a snapshot of a few of the current regulations whose comment periods are, as of this publication date, still open. CMS looks forward to hearing what you have to say and greatly appreciates the collaborative efforts of all involved in the regulations we administer. Please be sure to review the following regulations below by click on the associated link for their more complete descriptions and instructions for delivering your thoughts to us:

Hospital Inpatient Prospective Payment Systems and Fiscal Year 2004 Rates~ July 15, 2003
www.cms.hhs.gov/providerupdate/regs/cms1470p1.pdf

Inpatient Rehabilitation Facility Prospective Payment System for FY 2004~ July 7, 2003
www.cms.hhs.gov/providerupdate/regs/cms1474p.pdf

Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities~ July 7, 2003
www.cms.hhs.gov/providerupdate/regs/cms1469p2.pdf

Request for Nominations for Members for the Medicare Coverage Advisory Committee~ June 30, 2003
www.cms.hhs.gov/providerupdate/regs/cms3116n.pdf



Hot Transmittals & Instructions!

AB-03-089: Coverage and Billing for Home Prothrombin Time International Normalized Ratio (INR) Monitoring for Anticoagulation Management

www.cms.hhs.gov/manuals/pm_trans/AB03089.pdf

AB-03-076: Remittance Advice Message for Denial of Clinical Diagnostic Laboratory Services Denied Due to Frequency Edits

www.cms.hhs.gov/manuals/pm_trans/AB03076.pdf

AB-03-073: Provider Education Article: Financial Limitation of Claims for Outpatient Rehabilitation Services

www.cms.hhs.gov/manuals/pm_trans/AB03073.pdf

A-03-053: Nurse Practitioner Services Under Medicare Hospice

www.cms.hhs.gov/manuals/pm_trans/A03053.pdf

A-03-051: July 2003 Update of the Hospital Outpatient Prospective Payment System (OPPS)

www.cms.hhs.gov/manuals/pm_trans/A03051.pdf

B-03-043: Diabetes Outpatient Self-Management Training (DSMT) and the "Incident to" Provision

www.cms.hhs.gov/manuals/pm_trans/B03043.pdf

S&C-03-25: Clarification of Issues Related to Informal Dispute Resolution

<http://cms.gov/medicaid/ltcsp/sc0325.pdf>

Special Forum Notes

Thanks!

CMS would like to thank the National Rural Health Association (NRHA) for both its hosting and support of the May 16 Rural Health forum from Salt Lake City Utah. Also, CMS would like to extend thanks to the Indiana State Medical Association (ISMA) in Indianapolis, IN for their hospitality during the May 19 Physician forum from their headquarters.

Up Next!

The July 25 Physician forum hosted by the Association of American Medical Colleges (AAMC) in New York City. For more information of how to participate in our forums, please be sure to register at the Open Door Forum web-page at: www.cms.gov/opendoor/listservs.asp to receive your personal invitation.

For any information regarding the CMS Open Door Forum Initiative, please feel free to visit the home-page at: www.cms.hhs.gov/opendoor

